

(d) *Appeals.* The State, or HHS on behalf of the State, must provide an administrative process to appeal findings with respect to the implementation of risk adjustment software or data validation.

**§ 153.360 Application of risk adjustment to the small group market.**

Enrollees in a risk adjustment covered plan must be assigned to the applicable risk pool in the State in which the employer's policy was filed and approved.

[78 FR 15528, Mar. 11, 2013]

**Subpart E—Health Insurance Issuer and Group Health Plan Standards Related to the Reinsurance Program**

**§ 153.400 Reinsurance contribution funds.**

(a) *General requirement.* Each contributing entity must make reinsurance contributions annually: at the national contribution rate for all reinsurance contribution enrollees, in a manner specified by HHS; and at the additional State supplemental contribution rate if the State has elected to collect additional contributions under § 153.220(d)(1), in a manner specified by the State.

(1) A contributing entity must make reinsurance contributions for its self-insured group health plans and health insurance coverage except to the extent that:

- (i) Such plan or coverage is not major medical coverage;
- (ii) In the case of health insurance coverage, such coverage is not considered to be part of an issuer's commercial book of business;
- (iii) Such plan or coverage is appropriate health coverage, as defined by the Secretary; or
- (iv) In the case of employer-provided health coverage, such coverage applies to individuals with respect to which benefits under Title XVIII of the Act (Medicare) are primary under the Medicare Secondary Payor rules under section 1862(b) of the Act and the regulations issued thereunder.

(2) Accordingly, as specified in paragraph (a)(1) of this section, a contrib-

uting entity is not required to make contributions on behalf of the following:

- (i) A self-insured group health plan or health insurance coverage that consists solely of excepted benefits as defined by section 2791(c) of the PHS Act;
- (ii) Coverage offered by an issuer under contract to provide benefits under any of the following titles of the Act:
  - (A) Title XVIII (Medicare);
  - (B) Title XIX (Medicaid); or
  - (C) Title XXI (Children's Health Insurance Program);
- (iii) A Federal or State high-risk pool, including the Pre-Existing Condition Insurance Plan Program;
- (iv) Basic health plan coverage offered by issuers under contract with a State as described in section 1331 of the Affordable Care Act;
- (v) A health reimbursement arrangement within the meaning of IRS Notice 2002-45 (2002-2 CB 93) or any subsequent applicable guidance, that is integrated with a self-insured group health plan or health insurance coverage;
- (vi) A health savings account within the meaning of section 223(d) of the Code;
- (vii) A health flexible spending arrangement within the meaning of section 125 of the Code;
- (viii) An employee assistance plan, disease management program, or wellness program that does not provide major medical coverage;
- (ix) A stop-loss policy or an indemnity reinsurance policy;
- (x) TRICARE and other military health benefits for active and retired uniformed services personnel and their dependents;
- (xi) A plan or coverage provided by an Indian Tribe to Tribal members and their spouses and dependents (and other persons of Indian descent closely affiliated with the Tribe), in the capacity of the Tribal members as Tribal members (and not in their capacity as current or former employees of the Tribe or their dependents);
- (xii) Health programs operated under the authority of the Indian Health Service; or